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OBLIGATION AND THE CHANGING NATURE OF PUBLICLY FUNDED HEALTHCARE

SUMMARY

This article explores the relationship between obligation and publicly funded healthcare. Taking the National Health Service (NHS) as the focal point of discussion, the article presents a historical analysis of the shifting nature and function of obligation as it relates to this institution. Specifically, and drawing inspiration from recent literature that takes seriously the notion of the tie or bond at the core of obligation, the article explores how the forms of social relation and bonds underpinning a system like the NHS have shifted across time. This is undertaken via an analysis of Aneurin Bevan's vision of the NHS at its foundation, the importance today of the patient (and the individual generally) within publicly funded healthcare, and the role of contract as a contemporary governance mechanism within the NHS. A core feature of the article is its emphasis on the impact that a variety of economic factors – including privatisation, marketisation, and the role of debt and finance capital – are having on previously settled understandings of obligation and the forms of social relation underpinning them associated with the NHS. It is therefore argued that an adequate analysis of obligation in healthcare law and related fields must extend beyond the doctor-patient relationship and that of state-citizen of the

classical welfare state in order to incorporate new forms of relation, such as that between creditor and debtor, and new actors, including private healthcare providers and financial institutions.

Keywords: Contract; Creditor-debtor relation; National Health Service; Obligation; Privatisation; Publicly funded healthcare systems

I. INTRODUCTION

Arguably, rights – especially the elucidation, enumeration and pursuit of patients’ rights – have defined the *raison d’être* of medical law, healthcare law, and related fields, such as bioethics. Set against a critique of the alleged overweening power of medics and healthcare professionals, the objective of much writing in those fields, together with litigation initiated by patients themselves, has been to empower patients via the discourse of rights.¹ The right to receive adequate treatment information;² the right to choose whether or not to have an abortion;³ the right to refuse life-sustaining treatment;⁴ the right to access healthcare;⁵ the right to respect

¹ As Lords Kerr and Reed note in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at [75]: ‘[P]atients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.’

² See, e.g., M Jones, ‘Informed Consent and Other Fairy Stories’ (1999) 7(2) MedLRev 103. The Supreme Court has recently characterised the importance of patients receiving adequate treatment information prior to treatment as forming part of a right of autonomy or self-determination. See *Montgomery v Lanarkshire Health Board*, *ibid.* On self-determination in healthcare, see, for example, L C Edozien, *Self-determination in Health Care: A Property Approach to the Protection of Patients’ Rights* (Abingdon: Routledge, 2016)

³ JJ Thomson, ‘A Defense of Abortion’ (1971) 1(1) Philosophy & Public Affairs 47

⁴ *Re B (Adult: Refusal of Treatment)* [2002] EWHC 429 (Fam)

⁵ *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898

for one's private and family life;⁶ the right to be free from inhuman and degrading treatment;⁷ – these are just some of the rights that have been advanced in the cause of empowering patients and individuals *vis-à-vis* the medical and healthcare professions. If rights have received copious attention in the literature, what can be said of obligation?⁸ No doubt as a result, at least partly, of this focus on patients' rights and their desired implementation in practice, discussion of obligation in medical law and related fields has predominantly centred upon the types of duty (that might be) placed on doctors and other healthcare professionals. To cite just a few examples: the duty to disclose treatment information to patients;⁹ doctors' duty of professional confidentiality;¹⁰ the possible existence of fiduciary duties on the part of doctors;¹¹ all have been the subject of discussion and analysis in the literature. This is not to say that obligations fall solely on doctors in the field of healthcare law; states and public bodies also have duties in the healthcare context – for instance, in

⁶ A8 ECHR. See, for example, *The Northern Ireland Human Rights Commission's Application* [2015] NIQB 96. For discussion of human rights generally in the context of healthcare law, see, for example, E Wicks, *Human Rights and Healthcare* (Oxford: Hart, 2007).

⁷ A3 ECHR. See, for example, *D v United Kingdom* (1997) 24 EHRR 423.

⁸ This prioritising of rights over obligations has been noted recently in, and of, the legal academy and more generally: see, for instance, D Matthews and S Veitch (eds.), *Law, Obligation, Community* (Abingdon: Routledge, 2018) (part of the aim of which is to stress the primacy of obligations over rights), and S Moyn, 'Rights versus Duties: Reclaiming the History and Language of Human Obligations', available at:

<http://www.abc.net.au/religion/articles/2017/04/26/4659114.htm>. The theme of obligation has also been taken up at a sub-disciplinary level within law recently. In family law, for instance, see G Douglas, 'Towards an understanding of the basis of obligation and commitment in family law' (2016) 36(1) LS 1, and G Douglas, *Obligation and Commitment in Family Law* (Oxford: Hart, 2018).

⁹ See Jones, *op cit* and now *Montgomery v Lanarkshire Health Board*, *op cit*.

¹⁰ See, for example, B Ketels and T Vander Beken, 'Medical Confidentiality and Partner Notification in Cases of Sexually Transmissible Infections in Belgium' (2012) 20(3) *MedLRev* 399; J Tamin, 'What are 'Patient Secrets' in Occupational Medical Practice? Privacy and Confidentiality in 'Dual Obligation Doctor' Situations' (2015) 15(1) *MedLInt* 19.

¹¹ See, for example, P Bartlett, 'Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship' (1997) 5(2) *MedLRev* 193; J Harrington, 'Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment' (1996) 16(3) LS 348; and, S Ost, 'Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?' (2016) 24(2) *MedLRev* 206.

the field of public health and public health law,¹² and in the context of medical research.¹³ Traditionally, though, it has been around doctors and other healthcare professionals that the discussion of obligation in this field has predominantly revolved.

This article takes a different approach to the question of obligation in the healthcare sphere. Thus, the discussion of obligation occurs against a broader canvas than is usually encountered in the existing literature. Specifically, the theme of obligation is explored in the context of the changing nature of publicly funded healthcare systems, with the UK's National Health Service (NHS) functioning as the focal point of discussion.¹⁴ The article therefore presents a historical analysis of the shifting nature and function of obligation as it relates to this institution. It does so by way of three sections. The first considers some of Aneurin Bevan's writings on the NHS, identifying the nature of the type of institution he was intent on establishing and its differences from the system of healthcare that preceded it. What form of obligation can be detected in Bevan's writings? What principles underpinned his vision? How was the mode of funding he selected for the NHS related to those principles and obligation? These are the types of question that animate the discussion in this

¹² See, for example, L O Gostin and L F Wiley, *Public Health Law: Power, Duty, Restraint* (Oakland, California: University of California Press, 3rd edn, 2016)

¹³ See, for example, C Johnston and J Kane, 'Does the UK Biobank have a Legal Obligation to Feedback Individual Findings to Participants?' (2004) 12(3) *MedLRev* 239

¹⁴ For a discussion of the types of legal duty placed on institutional actors in the context of the NHS, specifically insofar as the rationing of scarce healthcare resources is concerned, see, for example, C Newdick, *Who Should We Treat? Rights, Rationing, and Resources in the NHS* (Oxford: Oxford University Press, 2005, 2nd Edition), and K Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge: Cambridge University Press, 2007). Newdick has recently raised a number of questions concerning, inter alia, the ethical duties of a variety of institutional actors in the context of the NHS. See C Newdick, 'Bioethics through the Telescope: Institutional Ethics in the NHS', in P R Ferguson and G T Laurie (eds), *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean* (Farnham: Ashgate, 2015), 125.

section. The remainder of the article discusses some contemporary literature and policy developments and examples directly relevant to the NHS and/or publicly funded healthcare systems generally. In doing so, the purpose is both to identify and chart some current forms of obligation, and to explore how these relate to, and mark a shift from, Bevan's writings. Thus, the second section presents an analysis of the relationship between the individual, obligation and publicly funded healthcare. The first part of this section considers some literature on patient obligation (itself much less written about in the fields of medical law, healthcare law, and bioethics than the obligations of doctors and healthcare professionals) and argues that what emerges from this is an idea of self-obligation – duties, for example, to work on one's own health – that seeks to ground a broader notion of a civic sense of patient obligation. The analysis then turns to consider the effects of marketisation on how patient (and more generally, individual) obligation might be understood in the context of today's NHS health and social care policy. Finally, the article explores the growing importance of contract as a means of governing various contemporary developments within the NHS. Through a discussion of some examples – including the Private Finance Initiative – the objective here is to reflect on what the role of contract can reveal about the changing forms and applicability of obligation in an era when the roles, *inter alia*, of finance capital, debt, and privatisation are steadily growing in importance within the NHS. Amongst other things, this involves a discussion of the function that contract plays today, and the degree to which citizens and states can be said to be voluntarily assuming contractual obligations.

In undertaking the foregoing analysis, the article takes seriously the key feature of obligation to be found at the heart of its etymology – namely the bond or tie. As Alain Supiot and others have noted, *ob-ligare* literally means to tie to or bind.¹⁵ Thus, Supiot argues that things that bind me to others – such as words or texts – create obligations. And Scott Veitch has explored how, *inter alia*, ‘this sense of tying or binding is a central component of understanding social and professional obligations, and indeed social and professional life’.¹⁶ When considering obligation in the healthcare context, this article is therefore not only interested in identifying types of substantive obligation, but also in exploring what these reveal about the shifting character of the ties and bonds that underpin a publicly funded healthcare system like the NHS. More specifically, it is the types of social relation that the obligations denote that this article is predominantly interested in exploring – something Nicholas stresses in his analysis of the meaning of *obligatio* in Roman Law:

To every right *in personam* there must obviously be a correlative duty: if A has a right that B shall give him a book, B must be under a duty to give A the book. The term *obligatio* denotes sometimes the right, sometimes ... the duty, but more properly *it denotes the whole relationship. Thus, etymologically it signifies a tying together – the bond which unites creditor and debtor*. It is a bond by which one party is bound, and the other entitled, to some act or forbearance, third parties being, in principle at least, unaffected.¹⁷

Thus, rather than conceptualising obligation in the sense of a correlative duty of a right, it is its understanding as ‘the whole relationship’ – the bonds of the relationship and what ties it together – that this article deploys. Adherence to this

¹⁵ A Supiot, *Homo Juridicus: On the Anthropological Function of the Law* (London: Verso, 2007) ix. See also, for example, S Veitch ‘The Sense of Obligation’, (2017) 8(3) *Jurisprudence* 415, and J I Guyer ‘Obligation, binding, debt and responsibility: provocations about temporality from two new sources’ (2012) *Social Anthropology* 20(4) 491.

¹⁶ Veitch, *ibid.*, 2.

¹⁷ B Nicholas, *An Introduction to Roman Law* (Oxford: Clarendon, 1962), 158. Emphasis from ‘it denotes’ added.

meaning allows one to think about obligations in a historical sense – that is, how the bonds, and the relations they signify, have altered over time. Relatedly, it also enables a focus both on how the form of existing relations – between citizen and state, for example – alters over time and how new forms of relation – for instance, between creditor and debtor – emerge and become prominent. It is one of the contentions of this article, therefore, that, in seeking to comprehend obligation in the field of healthcare, it is necessary to move beyond a concern merely with the doctor-patient relationship to consider other forms of relation and actors, including private healthcare providers and financial institutions. Moreover, and as the article seeks to demonstrate, while relevant to understanding how obligation is currently conceptualised in this area, an adequate grasp of this idea as it relates to the NHS demands moving beyond the traditional ‘ethical’ frame of analysis that tends to structure academic work in the field of healthcare law and related disciplines. In particular, there is a need to pay close attention to issues such as the economy, the importance of taxation, and the changing nature of citizenship.

Before beginning, one point should be noted. As mentioned above, the question of obligation is not confined to the doctor-patient relationship, but extends to other actors, including states and public bodies. Public health and public health law are two areas of scholarship that have engaged with health related matters at this broader level. While literature in those fields shares some themes – for example, the relationship between the individual and the state – with this article, the distinct focus and argument of the present work means that no attempt has been made to

engage in a discussion of this literature. Readers interested in exploring public health and public health law might consider consulting some of the texts listed below.¹⁸

II. HISTORICAL DIMENSIONS – ANEURIN BEVAN AND THE FOUNDING OF THE NHS

In light of the importance of the market to the analysis that follows, and the aforementioned utility of a historical dimension to this, a useful context for the discussion is provided by Aneurin Bevan's reflections in the early 1950s on the then recently established UK National Health Service.¹⁹ Bevan, the Labour Minister of Health commonly credited with having founded the NHS, framed the need for the creation of the NHS against the backdrop of an existing, predominantly market-based healthcare system, in which access to healthcare was only possible if one could either pay for it privately, was fortunate enough to be covered by insurance, or was aided by what Bevan called 'private charity and endowment'. It was this lack of universal access to healthcare that Bevan sought to redress via the creation of the NHS in 1948.

Bevan characterised the development of the NHS as having arisen from a conflict or struggle between commercialism and socialism. It was a healthcare system in which the prevailing profit motive was to be displaced as the principle governing preventive and curative medicine:

¹⁸ J Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge: Cambridge University Press, 2012); R Martin and L Johnson, *Law and the Public Dimension of Health* (London: Cavendish, 2001); J Coggon, K Syrett, and A M Viens, *Public Health Law: Ethics, Governance, and Regulation* (Abingdon: Routledge, 2016); Gostin and Wiley, *op cit.*; M Freeman, S Hawkes and B Bennett (eds), *Law and Global Health* (Oxford: Oxford University Press, 2014)

¹⁹ A Bevan, *In Place of Fear* (London: Heinemann, 1952), Ch. 5 ('A Free Health Service')

The same story is now being unfolded in the field of curative medicine. Here individual and collective action are joined in a series of dramatic battles. The collective principle asserts that the resources of medical skill and the apparatus of healing shall be placed at the disposal of the patient, without charge, when he or she needs them; that medical treatment and care should be a communal responsibility that they should be made available to rich and poor alike in accordance with medical need and by no other criteria. It claims that financial anxiety in time of sickness is a serious hindrance to recovery, apart from its unnecessary cruelty. It insists that no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.²⁰

For Bevan, the driving force behind the creation of the NHS was the idea that healthcare should not be viewed as a commodity – that is, as something produced for sale on a market. Thus, healthcare is to be available ‘without charge’; the healthcare system is to eradicate the feeling of ‘financial anxiety’ when ill; and its inclusion of those who ‘lack...means’ is to be what defines its civilised nature. Continuing in this vein, when devising the shape of the NHS Bevan proposed that GP practices – hitherto run privately and therefore disposable as property – should no longer be able to be sold: ‘I have always regarded the sale and purchase of medical practice as an evil’.²¹ It was ‘inconsistent with a civilized community ... for patients to be bought and sold over their heads’.²²

What, then, might Bevan’s discussion of the differences between medicine and healthcare pre- and post-NHS reveal about the changing nature of obligation and bonding in those eras? Prior to the NHS, the transaction between patient and doctor was mediated by contract, and it was this that bound the parties.²³ The contract,

²⁰ Ibid., 75.

²¹ Quoted in N Timmins, *The Five Giants: A Biography of the Welfare State* (London: HarperCollins, 1995) 119.

²² Ibid.

²³ As noted earlier, more collective, solidary forms of accessing healthcare – such as the National Insurance Act 1911 for employees, and friendly societies – existed prior to the creation of the

whereby parties are taken, formally at least, to meet as equals, created legal obligations – the patient had to pay the required fee and, assuming she did, the doctor was required to provide the relevant medical service. Moreover, implicit in Bevan’s critique of commercialism in the field of healthcare is a vision of social relations in which ‘the nexus [or bond] of man to man’ is ‘cash payment’.²⁴ Contract as the predominant source of legal obligations in medicine and healthcare is removed with the establishment of the NHS, and the legal obligation to provide a health service free at the point of need becomes a unitary one assumed by the State.²⁵ This much is clear from section 1 of the various incarnations of the National Health Service Act since the NHS’s commencement. The first Act of 1946, for example, reads as follows:

1.-(1) It shall be the duty of the Minister of Health ... to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services...

(2) The services so provided shall be free of charge, except where any provision of this Act expressly provides for the making and recovery of charges.

Decommodification of medicine and care and their characterisation as ‘a communal responsibility’, access to which is based solely on the criterion of need, demand that

NHS. While Bevan clearly identified positive aspects of such provisions and schemes, he highlighted some of their drawbacks too. These included their non-universal nature – both in terms of the groups and medical needs covered – and ‘patch-quilt’, non-rational structure. Such limitations meant that, for many, access to healthcare was dependent on one’s financial means, thereby rendering contract the key mediating device of the healthcare relationship.

²⁴ See T Carlyle, *Chartism* (New York: John B. Alden, 1885), in which Carlyle equated Industrial society with the notion of ‘Cash Payment as the sole nexus between man and man’ (at 52).

²⁵ It is important to note that contract does not become entirely irrelevant after the creation of the NHS. For instance, private forms of healthcare continue to be governed by contracts, which regulate the specific doctor-patient relationship. Thus, in the event of medical mishap for example, one would look to the terms of the relevant contract in the first instance, rather than to the law of tort. See, for example, *Thake v Maurice* [1986] QB 644. Private healthcare insurance also takes the form of contract and is available to those able and willing to purchase it.

the State assume the legal obligation to finance, and the Secretary of State for Health to become accountable for, healthcare services within the UK. In this scenario, it is no longer contract that is the binding device, creating obligations, but a certain form of principle – namely, that no citizen should be deprived of access to healthcare services owing to lack of funds. This principle of universal access irrespective of means posits a form of solidarity (that ‘communal responsibility’) that is the source of the legal obligation assumed by the state to provide to citizens a comprehensive health service free at the point of need.

This was borne out by the method of financing selected for the new health service – namely, general taxation. Bevan spends a fair amount of time discussing the reasons why he opted for this, as opposed to other, methods of finance. For instance, he dismisses the option of group insurance because:

All the insurance company does is to assess the degree of risk in any particular field, work out the premium required from a given number of individuals to cover it, add administrative cost and dividends, and then sell the result to the public. They are purveyors of the law of averages. They convert economic continuity, which is a by-product of communal life, into a commodity, and it is then bought and sold like any other commodity.

What is really bought and sold is the group, for the elaborate actuarial tables worked out by the insurance company are nothing more than a description of the patterns of behaviour of that collectivity which is the subject of assessment for the time being. To this the company adds nothing but its own profits. This profit is therefore wholly gratuitous because it does not derive from the creation of anything.²⁶

For Bevan, then, general taxation removed the element of profit and the idea of healthcare as a commodity from the rationale of the funding of the NHS. It is a mode of funding that exemplifies what Wolfgang Streeck has called the ‘tax state’, in that

²⁶ Bevan, op cit., 77.

the revenues used to fund, *inter alia*, mechanisms of social protection are raised via state taxes, rather than through other means, such as borrowing.²⁷ As well as this mode of financing the NHS involving an element of redistribution in the form of providing a healthcare service for all citizens irrespective of means, it can also be considered to reflect principles similar to those underpinning the old Roman Law notion of *obligatio in solidum* – namely, that each member of a group ‘is liable for the reversals of fortunes of another’²⁸ – something inherent in Bevan’s response to those critics who believed the creation of the NHS would give rise to a ‘something for nothing’ culture:

To call it something for nothing is absurd because everything has to be paid for in some way or another...To put it another way, you provide, when you are well, a service that will be available if and when you fall ill.²⁹

Bevan’s choice of taxation as the funding base of the NHS therefore points to more than simply a particular source of revenue for healthcare. It is also bound up with the socio-political meaning of taxation. Leroy, for instance, argues that the modern welfare state is synonymous with a “socio-financial democratic contract” which establishes a link “between mass taxation and social rights”.³⁰ In other words, there is an understanding that the legal obligation to pay taxes is inextricably linked to the provision by the state of various forms of social protection. Leroy also describes three forms of tax that capture the different legitimations underpinning the fiscal

²⁷ W Streeck, *Buying Time: The Delayed Crisis of Democratic Capitalism* (London: Verso, 2014), Ch. 2.

²⁸ M Pensky, *The Ends of Solidarity: Discourse Theory in Ethics and Politics* (Albany: SUNY Press, 2008), 6.

²⁹ Bevan, *op cit.*, 81-2.

³⁰ M Leroy, *Taxation, the State and Society: The Fiscal Sociology of Interventionist Democracy* (Bruxelles: Peter Lang, 2011) 319, quoted in S Frerichs, ‘From Social Rights to Economic Incentives? The Moral (Re)construction of Welfare Capitalism’ in T Kotkas and K Veitch (eds), *Social Rights in the Welfare State: Origins and Transformations* (Abingdon: Routledge, 2017), 137, 142.

contract. Thus, “obligation tax”, in which one pays one’s taxes because the law demands this, finds its legitimacy in legality; the legitimacy of “exchange tax” resides in the personal benefits (e.g. social services) one expects to obtain in exchange for the taxes one pays; and as Frerichs describes Leroy’s “contribution tax”: ‘[it] stands for a socio-political concept of taxation, according to which taxes are a legitimate contribution to the financing of regulatory and redistributive welfare policies, which may enjoy wide support even among taxpayers who do not immediately benefit’.³¹ It is suggested that this latter legitimation is the one underpinning Bevan’s vision of the NHS and the use of taxation as its funding base. For “contribution tax” is, as Frerichs notes, bound up with the common good and to be understood in solidary, rather than utilitarian (characteristic of the exchange tax), terms. We will return to Leroy’s ‘tax’ framework later.

Bevan’s vision for the NHS is therefore of a healthcare system in which obligation entails communal responsibility of, and for, each and all. This type of obligation is enshrined in the form of a statutory state duty to facilitate universal access to comprehensive healthcare services based solely on the criterion of need. With this historical dimension in mind, the remaining sections identify and discuss some types of obligation that, it is argued, can be detected within today’s NHS, and assess their implications for Bevan’s solidary vision of the NHS.

III. OBLIGATION, THE INDIVIDUAL, AND PUBLICLY FUNDED HEALTHCARE

³¹ Frerichs, *ibid.*

This section identifies and discusses the individual – predominantly the patient, but those with other care needs too – as an important bearer and discharger of obligations in the context of contemporary publicly funded healthcare. The analysis revolves around two focal points. The first, which emerges from a reading of some recent literature, identifies an idea of patient obligation as ethical obligation which, in turn, grounds the civic obligation of patients; the second, by reference to contemporary health and social care policy, concerns links between individual obligation and the market. There are various possible reasons for the emergence of interest in individual obligation in the area of publicly funded healthcare. While, as will be seen in the following subsection, these include concerns about the possibility of untrammelled patient power flowing from a particular conception of autonomy, they are also to be located in broader shifts in political fashion, especially the (enduring) popularity of “third way” thinking that stresses the importance of citizens’ obligations and not merely their rights. This political philosophy not only enables analysis of the different ways in which obligation attaches to individuals in this area; it also facilitates reflection on how these relate to Bevan’s vision of the NHS and related themes described above.

A. The Ethical and Civic Sense of Patient Obligation

This subsection explores some recent literature on patient obligation and draws out a few of its key themes.³² Turning first to an article by Draper and Sorell, the authors

³² The literature on patient obligation discussed in this subsection touches on themes – especially the relationship between the individual and the community – to be found in some work in the

question the seemingly unidirectional manner in which patient autonomy is understood within medical ethics – namely, that autonomy is equivalent merely to participation in the making of medical decisions, rather than to an acceptance of the consequences that flow from patients’ decisions.³³ They also analyse how patient obligations flow from what they call ‘general ethics’ – ‘from responsibilities to others and to the self, from duties of citizens, and from the responsibilities of those who solicit advice’.³⁴

The authors’ critique begins from the observation that medical ethics is concerned only with the ethical obligations of doctors, and not of patients. Arguing that the only real obligation on patients is to consent to treatment, they comment: ‘Little or nothing is said about what kinds of decisions patients *ought* to make. Nor is much said about their responsibilities for making good rather than bad decisions’.³⁵ Their argument is that autonomy ought to mean the same in medical ethics as it does in ‘general ethics’; that is, that autonomy is inextricably bound up with taking responsibility for decisions made.³⁶ Despite their vulnerability, patients can be negligent in making decisions that result in poor health outcomes, such that: ‘There may be an obligation in certain cases to live with certain decisions that leave them badly off’.³⁷

area of public health. For references to some of this public health literature, see J Coggon, *What Makes Health Public?*, op cit., especially 119 (footnote 57) and Ch. 8.

³³ H Draper and T Sorell, ‘Patients’ Responsibilities in Medical Ethics’ (2002) 16(4) *Bioethics* 335

³⁴ *Ibid.*

³⁵ *Ibid.*, 338. Original emphasis.

³⁶ This argument can also be found, for example, in M J Meyer, ‘Patients’ Duties’ (1992) 17(5) *Journal of Medicine and Philosophy* 541.

³⁷ Draper and Sorell, op cit., 340.

But, as Draper and Sorell's reference to the importance of 'general ethics' indicates, this ethical sense of patient obligation extends beyond the confines of the doctor-patient relationship to encompass the idea of respect for persons and the patient as citizen. Respect for persons includes treating hospital staff and GPs with respect by, for example, not abusing them while waiting to receive treatment in A & E, or failing to turn up for a scheduled GP appointment. However, it also encompasses an *obligation to oneself* to promote his or her own health and not to damage it – an obligation that 'ground[s] obligations to seek medical advice and listen to it'.³⁸ The idea of the patient as citizen comprises what Draper and Sorell call 'civic obligations'. In the context of welfare states, the authors argue that there are moral obligations upon patients to curtail their demands on finite public resources. This means there is 'a civic obligation to follow preventive health measures recommended by one's doctor'.³⁹ – to stop smoking or eating fatty foods, for instance. Those types of obligation involve obligations to the health care system and to other patients and take the form of 'duties not to use health services casually'.⁴⁰

Draper and Sorell note that the idea of an obligation to oneself can be found in Kant's moral philosophy and his notion of the noumenal self, where only this form of self is compatible with autonomy – the goal of morality – as it demands that one does not slavishly submit to one's base desires – eating or drinking excessively, to use one of Kant's own examples. But the noumenal self also grounds Draper and

³⁸ Ibid., 341.

³⁹ Ibid., 343.

⁴⁰ Ibid., 345. This idea of linking the moral supportability of patient obligations to a concern for the interests of other patients can also be found, for example, in H M Evans, 'Do Patients Have Duties?' (2007) 33(12) *Journal of Medical Ethics* 689.

Sorell's civic obligations (the patient as citizen); in order to preserve and enlarge the sphere of autonomy, one must have duties to have regard to others – in a universal healthcare context, not to make unlimited demands on a service with limited resources. Thus autonomy is bound up with obligation to oneself and one's fellow citizens, and it is only by discharging these obligations that true freedom is possible.

Draper and Sorell's article, and the themes within it, have been picked up within the legal field, where Brazier, as well as engaging in a discussion of the possible nature of patients' ethical obligations (for example, a patient duty to respect one's doctor's autonomy), has explored whether, and if so how, such ethical obligations might find expression within, and be enforced by, the law.⁴¹ Thus, the crux of the problem for Brazier in respect of patient responsibilities is not so much whether they exist in an ethical sense, which she accepts, but determining when the law should intervene to enforce these; should, for instance, the bioethical principles of beneficence and non-maleficence become legal, as well as ethical, obligations? Brazier argues that today autonomy is increasingly deployed as a justification for the expectation that patient choice regarding one's healthcare should be fully respected,⁴² rather than being confined, as it traditionally was, to the question of consent and the need to protect bodily integrity. Obligation, in this context, is firmly placed on the health service and members of the medical profession to implement patients' choices. Brazier

⁴¹ M Brazier, 'Do No Harm – Do Patients Have Obligations Too?' (2006) 65(2) CLJ 397. For a discussion of Brazier's argument in this article, see J Coggon, 'Would Responsible Medical Lawyers Lose Their Patients?' (2012) 20(1) MedLRev 130

⁴² With reference to Kant's work on autonomy, Onora O'Neill has similarly taken issue with such a consumerist understanding of autonomy – what she terms 'individual autonomy'. Kant's work, she argues, was instead synonymous with 'principled autonomy', which stresses the importance of obligation rather than an untrammelled right to choose whatever one desires. See O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002).

characterises such patient choices as a set of consumer demands. Like the literature discussed above, she highlights the importance of patients accepting responsibility for their choices, including considering the consequences of these for others. Patients have a duty of non-maleficence – a duty not to harm others’ health, by, for example, consuming too much of the healthcare system’s resources.

Draper and Sorell’s argument concerns what is here called the ethical sense of patient obligation.⁴³ What are some of its key features? First, it takes the form of a normative inquiry; in other words, it engages with the question of what particular kinds of obligation patients ought to have and the manner in which these should be discharged. Their article is replete with what patients should be doing, with what is morally wrong and right, and what must be done in certain (hypothetical) scenarios. Secondly, this sense of patient obligation has an other-regarding dimension that points, implicitly, to what was identified in the Introduction as a central characteristic of obligation – namely, the idea of a bond or bonding. This can be seen, for instance, in the context of claims that patients be empowered to participate jointly with doctors in treatment decisions. For Draper and Sorell, this ought to translate into a joint responsibility for the outcomes of such participatory decision-making, rather than patients being discharged of their responsibility for the negative implications of such decisions. As the authors note, this type of argument about patient obligation is underpinned by a sense of solidarity – that doctor and patient are jointly liable for the outcomes of collective decisions. Extending the relevance of

⁴³ For other examples of this ethical sense of patient obligation, see, for instance, DC English, ‘Moral Obligations of Patients: A Clinical View’ (2005) 30(2) *Journal of Medicine and Philosophy* 139, and the relevant literature cited therein; and Evans, *op cit*.

this idea to the more general level of publicly funded health care systems such as the NHS, some, like Evans, have argued that the notions of mutual benefit and mutual participation underpinning such systems should be accompanied by a series of patient duties, which are grounded in the importance of the common good and the common need (in the form of the interests of other patients).⁴⁴

It is suggested that those two features of the ethical sense of patient obligation are linked. This is especially so as regards Draper and Sorell's civic obligations which, insofar as they pertain to patients, ultimately involve obligations to the healthcare system and other patients who make use of it. Patients' obligations to reduce their demands on a healthcare system with finite resources by, for instance, promoting their own health and following preventive healthcare advice from doctors, are meant to ensure a measure of justice prevails in a healthcare system like the NHS. Placing inordinate demands on such a system potentially compromises its universal nature and its founding principle of access based on need. There is a strong sense here, though, in which the other-regarding dimension of those civic obligations – the bonds with others – is structured by obligations to one's self to act or behave in particular ways (the normative element). This is because the authors' argument – outlined above – involves treating the obligation to one's self to promote one's own health as the primary obligation that grounds, ultimately, patients' duties as citizens of welfare states. Thus, this obligation to one's self grounds the obligation to seek and follow one's doctor's advice – the heeding of which is an integral component of acting as a citizen of a welfare state. One might say that obligation, here, equates to

⁴⁴ Evans, *ibid.*, 689.

a series of moral injunctions to work on, and care for, the health of the self: promote your own health and do not damage it; follow preventive measures recommended by your doctor. Assuming and discharging such obligations will, among other things, mean that you will not require as much recourse to your publicly funded healthcare system, thereby enabling greater access by others; it will also mean that when you do require treatment, access will be more likely to be granted as you will be able to demonstrate a history of morally respectable behaviour in respect of your health – thus rendering you more deserving of treatment. In terms of bonding, then, it is suggested here that this idea of the civic obligation of patients can be characterised as being grounded in a form of self-binding: one is bound here to reflect on one's lifestyle insofar as it relates to one's health; to adopt measures that protect and promote health and prevent illness; in short, to live healthily and behave better in this respect, whatever that 'better' may mean. Insofar as the ethical sense of patient obligation is concerned, failure to act in such ways is perceived as an individual failing – implicit in Draper and Sorrell's reference to patients being capable of negligent decision-making – that may jeopardise one's access to state funded healthcare. As Zygmunt Bauman puts it: 'If [individuals] fall ill, it is assumed that this has happened because they were not resolute or industrious enough in following their health regime'.⁴⁵

Draper and Sorrell's characterisation of patients' 'civic obligations' resonates with a particular strain of discussion about, and controversy surrounding, the development and shape of both the NHS and the welfare state generally in the 1940s. For instance,

⁴⁵ Z Bauman, *Liquid Modernity* (Cambridge: Polity, 2000) 34. See also A Wardrope, 'Relational Autonomy and the Ethics of Health Promotion' (2015) 8(1) *Public Health Ethics* 50.

it can be detected in aspects of William Beveridge's vision of a welfare state in his 1942 Report on *Social Insurance and Allied Services*.⁴⁶ As Timmins notes, this vision stressed the importance of balancing a number of 'conflicting goals' – '[Beveridge] attempted to balance rights with duties, incentives against security, and individualism against collectivism'.⁴⁷ Beveridge's idea was that his Report's proposals would create what he called 'security with freedom and responsibility'.⁴⁸ Consistent with this vision, Beveridge's plan for a health service covering all citizens and forms of healthcare – 'positive and preventive as well as curative measures' – was premised on a combination of State *and* personal responsibility: 'Restoration of a sick person to health is a duty of the State and the sick person, prior to any other consideration'.⁴⁹ He speaks of the individual needing to 'recognise the duty to be well and to co-operate in all steps which may lead to diagnosis of disease in early stages when it can be prevented'.⁵⁰ While, as Timmins notes, it is important to stress the economic rationale behind Beveridge's vision of a new health service – namely, the desire to ensure at the time that, consistent with a policy of full employment, people were able to continue working⁵¹ – the key observation for present purposes is the emphasis Beveridge placed on the duties of individuals to remain healthy. For Beveridge, the new welfare state, including its health service, was never to be about shifting the onus of social protection solely to the state. Rather, his vision stemmed from a political philosophy, which, as Timmins notes, 'contained bits of Socialism and

⁴⁶ W Beveridge, *Social Insurance and Allied Services* (London: HMSO, Cm. 6404, 1942). The main objective of Beveridge's Report was to set out detailed proposals for a new social insurance system to tackle what he called 'Want'. Consequently, his discussion of a new national health service to tackle another of his five 'giants' – Disease – was necessarily brief.

⁴⁷ Timmins, *op cit.*, 57.

⁴⁸ Quoted in Timmins, *ibid.* 43.

⁴⁹ Beveridge, *op cit.*, 159.

⁵⁰ *Ibid.*, 158.

⁵¹ Timmins, *op cit.*, 24-5.

bits of Conservatism'.⁵² State protection was always accompanied by talk of incentivisation, individuals needing to help themselves, and the importance of curtailng abuse of the new social security system. As Aneurin Bevan noted some years later in his reflections on the creation of this institution, this concern about the potential for 'abuse' by citizens in the context of a new healthcare system based on the principle of free access at the point of need, formed an important reason advanced at the time by Conservative critics of the proposed NHS.⁵³ The enduring appeal of this type of concern can be found in Draper and Sorell's proposed 'duties not to use health services casually'.

As with the contemporary literature on patients' obligations discussed above, Beveridge envisaged the duties of the state and individuals in respect of healthcare as *ethical* obligations; and insofar as the latter were concerned, those duties were designed to foster self-sufficient individuals who needed to deploy their own resources to ensure a healthy existence. By undertaking this form of self-obligation – comprising work on the health of the self – citizens would simultaneously discharge obligations to themselves and others, thereby contributing to the sustainability of the NHS and the wider economy. In this form of citizenship, therefore, the public and the private are considered to be mutually reinforcing.⁵⁴

⁵² Ibid., 61.

⁵³ Bevan, op cit.

⁵⁴ It is clear from healthcare policy in recent decades that the form of ethical obligation as 'civic obligation' described above continues to be prominent. See, for instance, some of the patient responsibilities set out in the latest version of the NHS Constitution – The NHS Constitution for England (14th October 2015; available at: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>). For example: 'Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take responsibility for it.' The NHS Constitution was first published in 2009, and exemplifies the third way political philosophy – especially its focus on rights and responsibilities

B. Marketisation and the Obligation to Choose

The literature discussed in the previous subsection is essentially concerned with what is here called the ethical dimension of obligation – that is, with what ethical duties patients should have, the types of action they should undertake to discharge these, and the need to hold patients accountable should they fail to act in the stipulated ways. Arguably, what is missing in this analysis is any clear link to the themes and issues – the role of commercialism, healthcare as a commodity, and the importance of taxation, for instance – that played such a crucial role in shaping Bevan’s thinking regarding the character of the NHS. This matters as it is precisely those types of theme and issue that are reasserting themselves with such force within today’s NHS. Consequently, in order to present a more rounded analysis of patient obligation, it is suggested that attention also needs to be paid to what can broadly be called the economic context. While the question of the relationship of obligation to this context will form the remainder of this article, this subsection will consider the links between patient, and more generally individual, obligation and the creeping role of the market within the NHS.⁵⁵

At a general level, there is what might be called the obligation to act as a consumer in the context of publicly funded healthcare. Increasingly, patients must think of

– that defined the mode of government of both the New Labour administration in power at the time, and subsequent administrations. For a statement of ‘third way’ politics, see A Giddens, *The Third Way: The Renewal of Social Democracy* (Cambridge: Polity, 1998).

⁵⁵ In 2015-16, the private sector delivered a total of £8.7bn of NHS services, equivalent to 7.6% of the total NHS budget: <https://www.ft.com/content/297e7714-089f-11e7-97d1-5e720a26771b?mhq5j=e2>. For more information about the levels of involvement of private companies in delivering NHS services, see www.patients4nhs.org.uk.

themselves, and act, as consumers of healthcare.⁵⁶ For instance, they have a responsibility to give feedback on their treatment and experiences of the healthcare system,⁵⁷ and a legal right to make choices about their healthcare treatment, including where it should take place.⁵⁸ Thus, while there is, for example, no compulsion to make particular kinds of choice in this regard, there is no escape from thinking of oneself, and acting as, a consumer – that is, from making some sort of choice.⁵⁹ Obligation here concerns this broader compulsion of patients to act and think like consumers in the context of healthcare.

This idea of patients increasingly being obliged to act and think of themselves as consumers points to a different understanding of the relationship between obligation and choice to that identified earlier in existing work on patient obligation. In Draper and Sorell's, and Brazier's, analyses of the idea of autonomy, this relationship is understood in the sense of an obligation to accept the consequences of one's choices. From this standpoint, choices are not meant to be unreflective or equated with the mere satisfaction of preferences. Rather, they demand such qualities as self-control, abstemiousness, and a consideration of the effects of one's decisions on others. In contrast, the making of choices that lies at the heart of the obligation of patients to think and act as consumers does not demand such self-reflection because it is not bound up with judgments regarding the ethical nature or

⁵⁶ That patients are now widely perceived to be consumers who make choices, has also been noted, and recognised, by the courts. See *Montgomery v Lanarkshire Health Board*, op cit., at [75].

⁵⁷ This information is itself now becoming of interest to private companies, a development that has led some to argue that patient feedback now takes the form of a commodity to be traded in the marketplace. See D Lupton, 'The Commodification of Patient Opinion: The Digital Patient Experience Economy in the Age of Big Data' (2014) 36(6) *Sociology of Health and Illness* 856.

⁵⁸ See *The NHS Constitution for England*, op cit.

⁵⁹ See K Veitch, 'The Government of Health Care and the Politics of Patient Empowerment: New Labour and the NHS Reform Agenda in England' (2010) 32(3) *Law & Policy* 313

propriety of those choices. It is not so much an ethical obligation in the sense of patients accepting responsibility for their choices that affect their health; rather, the making of choices that defines the patient-as-consumer concerns the satisfaction of preferences, as patients effectively make choices, furnished with relevant information and statistics regarding levels of performance, based on where they would prefer to have medical treatment. The choices associated with the patient-as-consumer, then, do not assume an other-regarding nature in the sense, for instance, of considering the consequences of my behaviour (to live unhealthily; place inordinate demands on the health service etc) for other patients – especially their access to publicly funded health care. Rather, the obligation of patients to act and think like consumers is bound up with the marketisation of such a healthcare system as it demands that patients choose from a range of options. Again, this understanding of choice differs from that to be found in Brazier's work, for example, as it is not about a right to have one's choices about one's healthcare – the particular treatment or healthcare service – met in full. Choice here does not necessarily equate to a right to demand any treatment a patient wants;⁶⁰ rather, the demand is placed upon the patient to choose from a range of options of healthcare provider or treatments. Unlike your choices about whether or not to heed your doctor's advice, nobody will necessarily hold you responsible for the manner in which you select between different providers or treatments because these are choices driven by *preferences* rather than by ethical or civic considerations.⁶¹ To the extent that the

⁶⁰ Such a 'right', in any case, is subject to a variety of factors, such as the rationing of healthcare resources. See Syrett 2007 and Newdick 2005, *op cit*.

⁶¹ It should be noted that some authors make the argument that some kind of collective or public benefit can be derived from market participation. Hayek, for instance, argues that coercing individuals to make provision for themselves via the market in respect of various social risks

latter dimension can be interpreted as being equated to the types of solidary bond characteristic of the classic welfare state, one might describe a shift in the notion of the patient from the idea of the patient as citizen of the welfare state to the patient as consumer-citizen.

This shift to the importance of marketisation and the choice agenda can be illustrated by reference to an example – the system of payments to those in need of care known as ‘direct payments’. These are sums of money provided to individuals by public institutions, which individuals use to purchase care services for themselves.⁶² The aim is to give individuals more flexibility in how their services are provided. The relevant website says: ‘If you need care and support, this had in the past been provided direct from your local council. Direct payments were introduced to give people more choice and control over how their care and support was arranged, to help them live more independently’.⁶³ Certain obligations can accompany the choice to receive direct payments, including, firstly, the requirement to keep records and account to social services for how the money is spent; and,

prevents them becoming ‘a charge to the public’. He also, for example, warns against the dangers of inefficiency associated with the monopoly provision of services. But the form of collective interest Hayek can be taken to be concerned with protecting is very different from the original solidary aims, based on the principle of need, that define an institution like the NHS. Thus, his rationales for coercion in relation to the private provision against social risks just mentioned is ‘to forestall greater coercion of the individual in the interest of others’ and ‘the desire of individuals to protect themselves against the consequences of the extreme misery of their fellows.’ F A Hayek, *The Constitution of Liberty* (London and New York: Routledge Classics, 2006), 249. Fundamentally, Hayek’s understanding of collective interest is one associated with the protection of individual liberty and the institution of competition as ‘the principle of social organisation’ (F A Hayek, *The Road to Serfdom* (London: Routledge, 1944)), 26.

⁶² Strictly speaking, such individuals are not patients, but individuals in need of social care. Nonetheless, given the move to align health and social care services – something indicated in the title chosen for recent legislation (the Health and Social Care Act 2012) – and that payments are made by local Health and Social Care Trusts, it is suggested that direct payments provide a useful example of changes in individual obligation associated with publicly funded healthcare.

⁶³ See: <https://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/direct-payments-personal-budgets.aspx>

secondly, the assumption of the legal role of an employer if you are using the payment to pay for a care worker, together with undertaking all the legal responsibilities that go with this. Help, the website says, may be available from local organisations to manage the administration involved and other responsibilities of being an employer.

What can direct payments and the obligations accompanying them reveal about obligation as it is being discussed in this article? First, although not mentioned on the website, the most obvious obligation inherent in the direct payment is the obligation to spend it. As noted, rather than providing the service itself, the state provides money which, in order to obtain the service, the individual must spend. This necessarily involves making a choice as to which provider will provide your care. This obligation to act as a consumer of care services is therefore bound up with the creation and maintenance of a market for the provision of publicly funded health and social care for it is inextricably linked to the promotion of competition amongst health and social care providers. Spending one's direct payment necessarily fosters this form of competition and points to the commodification of this type of care in that it can now be understood as being produced for sale on a market. Second, the typical obligations accompanying one's spending of the direct payment – to keep records and account for one's spending, and to assume the role of legal employer of the care worker – have implications for both our understanding of what an individual in need of care is and the shifting onus of assuming and discharging obligations. Thus, on the one hand, these obligations demand of the individual that he or she function as a sort of small business – assuming the roles of an accountant and employer. This

transforms the common understanding of what someone in need of care is, in that it assumes characteristics of activity rather than passivity; demands the development of a particular skill set – those associated with management/business; and requires consumption rather than the simple use of a public service. On the other hand, direct payments involve a clear shift in the assumption and discharge of obligations from the state to the individual. Discretion as to how to allocate the resources of publicly funded health and social care (spending the direct payment in this case) and the associated management that comes with this allocation (keeping records etc.) shifts to become the province of the individual, rather than of the state – the sole obligation of which seems to be to provide money to individuals to spend as they see fit.⁶⁴ Indeed, there appears to be an imposition of obligations by the state upon the individual that, because money is still provided by the state, is absent in the context of a transaction between private parties. Thus, the state has the power not only to demand accountability in the manner in which the money is spent, but, to create new relationships and forms of obligation – between employer and employee, say – that were previously alien to the manner in which citizens obtained publicly funded health and social care services from the state. In the present example, this results from the state's reformulation of its role from that of a service provider to one of a dispenser of money.

⁶⁴ As an aside, this kind of example would appear to represent an interesting development in the context of a particular genre of critique of the welfare state that pinpoints one of its key failings as being the detrimental effect on individual freedom of the large amount of discretionary power exercised by state institutions and officials (on which, see, for example, F Hayek, *Law, Legislation and Liberty*, Volume 2: *The Mirage of Social Justice* (London and New York: Routledge Classics, 2013)). The 'direct payments' example would seem to shift discretionary power away from the state and grant it to the individual, thereby providing a sense of individual freedom comparable to that desired by critics of the traditional welfare state. As argued, however, new forms of obligation, this time associated with the state's desire to model welfare along market lines, accompany the exercise of one's discretion to spend the payment.

The forms of obligation described and discussed in this subsection can all be considered to be linked to the increasing prevalence of the market within the NHS and social care. Individual obligation appears here in a different guise to that encountered in the current literature on patient obligation. Thus, it does not so much take the form of moral injunctions as modes of action required for the realisation of economic ends. Thus, the obligation to choose concerns the drive to force patients to think of themselves as consumers and, in doing so, of the NHS as just another site in which market relations operate. And the obligation to spend public funds by purchasing social care enables the creation of new markets in this type of care, while simultaneously fostering new forms of legal relationship (between employer and employee, for instance) and obligation within the health and social care sphere. Finally, there is a sense in which the examples discussed in this section point to the re-emergence of the cash nexus as the predominant form of bond within the contemporary NHS and health and social care policy.

Those developments and the emphasis on individual obligation generally, described in this section, sit uneasily with Bevan's characterisation of the NHS. Thus, whereas Bevan saw the manifestation of the collective dimension of the NHS in the state's assumption of the obligation to provide access to healthcare based on need and funded via general taxation, it is argued the realisation of this collective aspect in the literature discussed above is grounded in the primacy of individual obligation in the form of work on the care of one's own health. Inextricably linked to this is a moralising discourse of patient obligation focused on judgments regarding individual

behaviours and lifestyles – the suggestion being that failure to take individual responsibility for one’s health may result in state healthcare services becoming inaccessible, despite clinical need. As such, it has resonances of the ‘something for nothing’ argument that, as noted earlier, Bevan was quick to dismiss as a potential danger of the new NHS. Obligation, here, equates primarily to a process of self-binding – of being bound to work on the self such that one’s actions conform to unspecified levels of moral conduct. As the direct payments example illustrates, this self-binding also involves a process of transforming how we think about ourselves; thus, rather than as individuals in need of care services, we need to perceive ourselves as consumers (obliged to choose from the various providers competing on the market for social care that such payments inevitably help to construct); as enterprises managing our own social services, those who provide them, and all the administration that accompanies this. In short, the foregoing features are characteristic of a neoliberal society and politics, in which, according to Dardot and Laval, ‘at stake...is nothing more, or less, than the *form of our existence* – the way in which we are led to conduct ourselves, to relate to others and to ourselves’.⁶⁵ This also has implications for understandings of citizenship. As Dardot and Laval note:

Citizenship is no longer defined as active participation in the definition of a common good specific to a political community, but as a permanent mobilization of individuals who must engage in partnerships and contracts of all kinds with enterprises and associations for producing local goods that provide consumers with satisfaction. State action must above all aim at creating conditions conducive to the action of individuals – an orientation that tends to dissolve the state into the set of producers of ‘public goods’.⁶⁶

⁶⁵ P Dardot and C Laval, *The New Way of the World: On Neoliberal Society* (London: Verso, 2013)

3. Emphasis in original.

⁶⁶ *Ibid.*, 188.

Arguably, this transformation in the meaning of citizenship charts the shift from Bevan's vision of the NHS as a common good available for all and based on the principle of solidarity to the consumer-oriented NHS of today in which citizenship, as the examples discussed above demonstrate, equates to the obligation to enter agreements to provide public goods that satisfy individuals. This leads us conveniently into the article's final substantive section, which considers the contemporary importance and role of contract in the NHS and its links to obligation and questions of economy.

IV. OBLIGATION AND THE RE-EMERGENCE OF CONTRACT

Earlier, it was noted that the decommodification of healthcare that accompanied the creation of the NHS saw the erosion of contract as the legal medium through which much access to medical and healthcare services was facilitated. What is notable today, however, is the re-emergence of this legal institution as an important mechanism through which various aspects of the NHS are managed. By way of some examples relating mainly to the growing importance of private finance and private providers of healthcare within the NHS, this section's purpose is to reflect on the broader functions contract can be understood to be performing in this context today, what implications these have for notions of obligation and the form of social relations underpinning the NHS, and what this means for traditional ideas of contract.

A. The Private Finance Initiative (PFI) – Contract, Discipline and the Shifting Contours of Obligation

The first example is the Private Finance Initiative (PFI). In the context of healthcare, this has been widely used by governments to fund the construction of NHS hospitals. Private contractors raise the money to finance this from banks and shareholders and, via the PFI contract, own and manage the hospital. Clinical Commissioning Groups (CCGs; formerly NHS Primary Care Trusts) lease the hospital and staff, such as cleaners, from the contractors, paying a 'unitary charge' for these from their annual health care budgets. The capital raised to finance the building of hospitals must also be repaid, together with the high rates of interest accruing on this. Those payments also come from the NHS budget. Contracts, and thus the repayments, last for periods ranging from 25-40 years, although once they are paid off, the NHS does not necessarily end up owning the premises. The PFI as a form of funding public projects such as the building of hospitals has been controversial, not least as the levels of repayment from the NHS budget required to service the debt and accruing interest produce high deficits and result in less money for NHS Trusts to spend on healthcare for patients. A few figures are useful here. Between 2010 and 2015, the NHS and local authorities in England spent a total of £10.75bn on hospitals and other healthcare facilities built under the PFI scheme. Currently, the Department of Health oversees 125 PFI contracts with private companies. The value of the assets that have been built is £12.4bn. However, over the lifetime of the contracts, the NHS will pay £80.8bn to use these assets. For 107 of the 125 PFI contracts, the PFI companies have made pre-tax profits of £831m in the past 6 years. This profit is additional to

the profits made by others from those contracts, including banks on the loans for the building work, construction companies, and companies maintaining the hospitals and providing services. 8% of the money paid to the PFI companies in the past 6 years has been in the form of pre-tax profit and, thus, cannot be used for patient care. Finally, £480m of dividends was paid out on these contracts, representing almost 5% of all of the money the NHS paid.⁶⁷ But as well as the practical implications of this for healthcare, what can the PFI scheme reveal about the shifting nature of obligation within the NHS?

One way into this question is to conceive of the PFI scheme as illustrative of Streeck's analysis of the shift from the tax state to what he calls the debt state. Unlike the tax state, in which, as noted earlier, governments raise the revenues needed to fund, say, adequate public services through sufficient levels of taxation, the debt state is characterised by low tax receipts, with the shortfall in revenue necessary for government expenditure having to be made up through borrowing in the form of debt.⁶⁸ While this is clearly the case regarding the source of revenue for PFI projects, it is also crucial to note that the tax state continues to play a central role here (albeit one having a different function to that described by Streeck – namely, the funding of adequate public services). This is because the revenue available from taxation increasingly needs to be used for the purpose of servicing debt, rather than for the provision of public services. This is what would appear to be

⁶⁷ For those figures and more analysis, see Centre for Health and the Public Interest, P.F.I.: Profiting From Infirmaries (August 2017), 4. The figures in this Report are based on a study of the official Treasury database on PFI schemes and the accounts of PFI companies, which are held by Companies House.

⁶⁸ Streeck, *op cit.*, 72-3.

happening in the case of the PFI, where, as noted, repayment of the capital deployed to build NHS hospitals, together with the ongoing interest payments on what is effectively a loan, are financed through the tax revenues that continue to form the funding base of the annual NHS budget. A number of observations can be made regarding this. First, it is necessary to update partially Bevan's equation of the selection of general taxation as the funding base for the NHS with the removal of the profit motive in healthcare. For, while revenue raised from taxation continues to fund the delivery of healthcare, it also increasingly acts as a source of revenue and profit for the private sector – here in the form, *inter alia*, of interest payments on debt.⁶⁹ One way of thinking about this revenue stream is as a form of rent paid to creditors over many years – a gratuitous form of revenue, to use Bevan's description of the nature of the profits he argued were added to insurance premiums but did not 'derive from the creation of anything'.

Secondly, this demands revisiting the notion of obligation as it has traditionally been understood in the context of the NHS. It was argued earlier that Bevan's vision for the NHS could be thought to embody the 'all for one and one for all' principle to be found in the Roman Law notion of *obligatio in solidum*. If, rather than referring simply to either the creditor's right to something or the debtor's correlative duty in relation to that right, the *obligatio* 'more properly denotes the whole relationship [between creditor and debtor] ... signif[ying] a tying together – the bond which

⁶⁹ In his discussion of the more general picture surrounding contemporary debt relations, Maurizio Lazzarato says this: 'Through the simple mechanism of interest, colossal sums are transferred from the population, business, and the Welfare State to creditors.' M Lazzarato, *The Making of the Indebted Man: An Essay on the Neoliberal Condition* (Los Angeles, CA: Semiotext(e), 2012) 20.

unites creditor and debtor', the bond envisaged by Bevan could be thought of as being grounded in an idea of reciprocity and sense of fairness in which 'you provide, when you are well, a service that will be available if and when you fall ill'. Crucially, the binding device here, it was argued earlier, is a certain principle – namely, that no citizen should be deprived of access to healthcare services owing to lack of funds. The PFI scenario presents a more complicated picture of obligation. On the one hand, there is what can be called a communal responsibility of taxpayers for the repayment of debt and interest associated with PFI projects. In this sense, it can be seen to be truer to the original substance of the *obligatio in solidum*, which concerned joint liability for financial debt.⁷⁰ Moreover, the ideas in this Roman Law conception that liability, rather than blood or love, is the bonding force, and, as Pensky notes: 'We are bound together with those with whom, like it or not, our own fates and our own well-being are interwoven',⁷¹ can be thought to be directly relevant to the PFI scenario too. On the other hand, the nature of the bond differs. Thus, if Bevan's choice of taxation as the financial source of the NHS was meant to signify the solidary bonds amongst taxpayers (who might be thought to represent the debtors and creditors of the *obligatio in solidum*), based on the principle of liability 'for the reversals of fortune of another' within the group⁷² – you pay when you are well and benefit when you become ill – insofar as the PFI is concerned, taxpayers are bound not to one another in a collective relationship defined by reciprocity or a sense of fairness, but through debt and interest, to finance and its

⁷⁰ Pensky, op cit., 6.

⁷¹ Ibid.

⁷² Ibid.

demands and operating rules.⁷³ While this takes the form of a communal liability, it is one owed to parties (creditors) outside of the group (citizens) Bevan envisaged in his vision of the NHS. This new form of bond is between taxpayers and finance capital. The sense of creditor and debtor is no longer that identified above – namely, of the well and the ill in need of access to healthcare services – but assumes its more recognisable financial meaning. One consequence of this is that our fates and well-being are no longer interwoven solely with fellow citizens, but become increasingly bound together with the imperatives of finance capital – specifically its compulsion to make a profit.⁷⁴ Another is that taxation loses the solidary and decommodifying character Bevan ascribed to it, assuming instead a commercial dimension (the ‘private acquisitiveness’ of which Bevan spoke), in that it functions as a source of ongoing rent and profit for finance.

Moreover, obligation here can be characterised as disciplinary and opaque. It is disciplinary in that taxpayers are effectively legally obliged over a period of decades to use part of the taxation that comprises the national budget for healthcare to repay debt and the high interest payments associated with this.⁷⁵ It is opaque in that this type of obligation is rarely publicised,⁷⁶ certainly in comparison with the forms of obligation in the field of contemporary healthcare identified earlier – such as the injunctions directed at citizens to work on their health or make choices about their

⁷³ R Dienst, *The Bonds of Debt: Borrowing Against the Common Good* (London: Verso, 2017)

⁷⁴ See K Veitch, ‘Law, Social Policy, and the Constitution of Markets and Profit Making’ (2013) 40(1) *J Law & Soc* 137, 147-8.

⁷⁵ On the relationship between debt and discipline, see, for example, T Mahmud, ‘Debt and Discipline’ (2012) 64(3) *American Quarterly*, 469 and S Soederberg, *Debtfare States and the Poverty Industry: Money, Discipline and the Surplus Population* (Abingdon: Routledge, 2014)

⁷⁶ It should be noted that PFI contracts themselves are often subject to commercial confidentiality clauses, something that contributes to the opacity under discussion.

treatment. Its opacity also contrasts with the typical debate over NHS resources, which, though crucial in itself, often assumes a quantitative character, revolving around the extra resources needed by the institution rather than identifying the causes of that need, which, as the PFI indicates, would necessarily encompass the non-healthcare related directions in which the NHS budget can flow. This is therefore a hidden form of compulsion, whose implications, however, such as hospital closures and cutbacks in healthcare services, are all too evident to the eye. This opacity can be considered to be linked to discipline in that the less transparency these obligations on taxpayers are afforded, the more deeply embedded this form of the debtor-creditor relationship becomes.

This also has potential implications for the form of legitimation underpinning the fiscal contract, which was discussed earlier. There, by reference to Leroy's three forms of tax, it was suggested that his notion of "contribution" tax, in which the legitimacy of taxation is bound up with redistributive welfare policies that may garner the support of those who may not be immediate beneficiaries, underpinned Bevan's vision of the NHS. While this no doubt continues to be relevant to the contemporary NHS, it would not capture the function of taxation *vis-à-vis* the PFI described above, which, as noted, is used to manage interest, as well as capital, repayments. Nor would Leroy's "exchange tax" seem to capture the legitimacy of the fiscal contract here. For, while it could be argued that, in exchange for their tax payments, taxpayers obtain new hospitals in which to receive healthcare, it is difficult to see what is received in return for the high, ongoing interest payments that must be made over decades. They appear, to repeat Bevan's words, to amount

to gratuitous forms of revenue that do not result from the creation of anything. This leaves Leroy's final form – the “obligation tax” – which may well be the most relevant to this scenario. That is, taxation finds its legitimacy in legality – one pays one's taxes for no other reason than because this is a legal demand emanating from a formally rational legal system or order.⁷⁷ From the point of view of legitimacy, the precise uses to which taxation is put – whether it furthers social justice, for instance – is neither here nor there insofar as the “obligation tax” is concerned, as legitimacy is intrinsic to the legal order itself.

The third observation concerning the PFI is that it operates via the legal institution of contract. This is important for two reasons. First, it signals the re-emergence today of the importance of contract as a legal mechanism for the regulation of healthcare and the implementation of healthcare policy.⁷⁸ As discussed earlier, Bevan's vision for the NHS was to move away from a commoditised form of healthcare characterised by the doctor-patient relationship governed by contract. But, as in other areas of welfare,⁷⁹ contract has reappeared within contemporary healthcare as one of the regulatory tools of choice. This matters because, at least as the example of the PFI demonstrates, contract again reappears simultaneously with the reintroduction of the importance of the money relation within healthcare. And, as with the contracts characteristic of pre-NHS healthcare, it is the cash nexus that is emerging as the preferred type of bond within the contemporary NHS – the

⁷⁷ See M Weber, *Economy and Society: An Outline of Interpretive Sociology*, Volume One (Berkeley, CA: University of California Press, 1978)

⁷⁸ For an important discussion of the emerging role of contract in the move within medical law towards individualism and what the author calls the development of a ‘process-utopia’, see J Harrington, *Towards a Rhetoric of Medical Law* (Abingdon: Routledge, 2016) Ch. 5.

⁷⁹ For some examples of the deployment of contract within social policy, see P Vincent-Jones, *The New Public Contracting: Regulation, Responsiveness, Relationality* (Oxford: OUP, 2006)

difference being that it is debt and the imperatives of finance that constitute the ties of today's PFI contracts. Secondly, the disciplinary character of the PFI, outlined above, exemplifies what some have argued is a transformation in the function of contract in recent years. Alain Supiot, for instance, has noted a shift from the original understanding of contract as involving obligations created by parties who have freely assumed reciprocal obligations, to 'agreements' that simply generate obligations whether or not parties have agreed to them – similar to what contract lawyers call contracts of adhesion. Contracts therefore assume a more regulatory function today. They are the mechanisms by which some are supervised; by which force is exercised (if you must enter into contracts): 'the user is transformed into a party obliged to contract...'.⁸⁰ He summarises these developments by saying that what we are witnessing is the emergence of new forms of contracts the principal aim of which is 'to legitimate the exercise of power'.

This regulatory function of contract can be witnessed in the field of contemporary healthcare. It is evident in the example discussed above – namely, the PFI scheme. For, despite the contracting party being the state, rather than taxpayers *per se*, given the source of funding to repay the capital and interest of PFI arrangements in the healthcare sector is general taxation and that such payments can have negative impacts on citizens' access to healthcare services (as less money means cutbacks, closure of hospital departments or, in the worst case, whole hospitals), PFI contracts can be considered to discipline taxpayers by imposing obligations on them regardless of whether or not they have, or indeed would, agree to them. The same could be

⁸⁰ Supiot, *op cit.*, 104.

said, for example, of the recent junior doctors' strike in England. For the strike itself revolved around what the doctors argued was the blatant attempt by the Secretary of State for Health to impose a new contract upon them in his pursuit of the implementation of a Conservative party manifesto commitment to introduce a seven-day NHS.⁸¹ The doctors argued there had been a lack of meaningful prior consultation or negotiation over the contract's proposed terms and conditions, including weekend working – something, they argued, would disproportionately affect those junior doctors who worked less than full time and those who worked the most weekends. For the doctors, this was not a scenario involving equal parties freely assuming reciprocal obligations so much as one in which one party sought to impose obligations forcibly irrespective of the other's agreement to them. Contract here was deployed as a tool for disciplining members of the medical profession – obliging them to work at certain unsociable times of the week in order to satisfy what was characterised as an overwhelming public demand. Moreover, common to the deployment of contract in the doctors' and taxpayers' scenarios is not only a sense of the parties having no say over the particular contract's terms and conditions, but over the wider forces lying behind those particular contracts too. Writing of contemporary debt relations and obligation, Scott Veitch argues that not only do citizens find themselves bound into practices of indebtedness in various spheres of life, they are also 'not in a position to bargain *about* the ground rules' – namely the laws of the market.⁸² Framing his analysis in Viscount Stair's notion of 'obediential obligations' – that is, obligations that are 'pre-contractual, pre-institutional, pre-

⁸¹ See, for example, A Rimmer, 'Junior Doctors Announce Five Days of Full Strike Action' (2016) 354 BMJ i4753

⁸² S Veitch, *op cit.*, 15. Emphasis in original.

experiential', and, thus, do not derive their binding force from 'positive laws, [or] from human agreements' – Veitch argues that non-negotiability extends to the broader economic forces from which these particular types of obligation emanate.⁸³ As Maurizio Lazzarato, in his discussion of the debtor-creditor relationship – which he takes to be the key relationship of our age – somewhat grandly puts it: '[Debt] intensifies mechanisms of exploitation and domination at every level of society' and encompasses all agents and classes: 'Everyone is a "debtor," accountable to and guilty before capital. Capital has become the Great Creditor, the Universal Creditor.'⁸⁴ Similarly, via PFI contracts, citizens become bound into circles of debt arising from the needs and requirements of finance capital, and, via new employment contracts, doctors into labour practices driven by the purported demands of a fast-paced 24-7 society and the exigencies of flexible labour markets. Contract therefore becomes equated with *non*-negotiability and discipline, rather than with the negotiated construction of freely assumed reciprocal obligations that Supiot identifies as the defining characteristic of the traditional idea of contract.⁸⁵ To what extent, if at all, states are similarly subject to blind economic forces and the laws of the market will be discussed towards the end of this section.

B. Privatisation, Contract and the Avoidance of Obligation

If contracts in the sphere of publicly funded healthcare can be understood effectively to impose obligations on certain contracting parties, there is also evidence indicating

⁸³ Ibid.

⁸⁴ Lazzarato, op cit. 7.

⁸⁵ And that Stair associated with what he called 'conventional' obligations.

that other parties escape liability – either owing to lack of assignation of contractual obligations or because those that exist within the contract are not enforced. The following are some examples of this relating to the role of marketisation and the private sector in the NHS. First, and sticking with the PFI, some have argued that an asymmetry of obligation can be detected regarding the risks assumed by the state and finance in PFI contracts, with finance being protected from a variety of economic risks. As Pollock et al note, these contracts rarely transfer economic risks to the funding consortium, with the result that these usually fall on the state and taxpayers. For instance: ‘Where a Trust wishes to terminate a contract, either because of poor performance or insolvency of the private consortium, it still has to pay the consortium’s financing costs, even though the latter is in default’.⁸⁶

A similar scenario can be witnessed insofar as the provision of NHS services by private companies is concerned. Contracts for the outsourcing of the delivery of NHS healthcare to private companies are now common, something aided by the obligation placed upon clinical commissioning groups (CCGs) to establish a tendering process for the commissioning of health care services in furtherance of the embedding of the principle of competition within the NHS that is a core feature of the Health and Social Care Act 2012.⁸⁷ However, two features of this outsourcing of NHS healthcare have caused concern. The first is that, owing to the manner in which the contracts have been constructed, providers have been able to withdraw from their contractual obligations (sometimes well) before the contract’s end date,

⁸⁶ AM Pollock et al, ‘Private Finance and “Value for Money” in NHS Hospitals: A Policy in Search of a Rationale?’ (2002) 324 BMJ 1205, 1208-09.

⁸⁷ See s.75, Health and Social Care Act 2012.

leaving a gap in service provision and the NHS to undertake the costly process of finding a new bidder to replace the company that has left. The reasons given for early withdrawal have included claims that NHS funding has been cut and demand for access to particular types of health service (Accident & Emergency, for example) have surged,⁸⁸ suggesting that changes detrimentally affecting companies' expected financial returns have been central to providers' decisions to withdraw. The second feature concerns the weak capacity and reluctance of CCGs to enforce the terms, and hence the obligations within, contracts between CCGs and private providers. In its 2015 survey of 181 CCGs, the Centre for Health and the Public Interest (CHPI) found that only 7 out of 15,000 contracts between CCGs and private companies had been terminated for poor performance; only 134 contract query notices had been issued; and just 16 CCGs had imposed any financial sanction on private providers owing to poor performance.⁸⁹ The reasons for this weak monitoring and enforcement are many, but include a lack of capacity on the part of CCGs to monitor and enforce contracts; 'asymmetry of information' such that it is very difficult for CCGs 'to know whether a provider is delivering according to the terms of the contract, or is cutting corners or reducing quality in order to gain extra revenue'.⁹⁰; and a fear of compounding the already difficult financial positions of private providers (in other words, a reluctance by CCGs to impose financial penalties on private providers as such penalties remove money from places that are struggling).

⁸⁸ For instance, those reasons were given by Circle – a private company – for its withdrawal from the contract to run Hinchingsbrooke NHS general hospital in Cambridgeshire. It withdrew two years into a ten-year contract. For further examples of early withdrawal of private companies from contracts to provide NHS services, see: <http://www.nhsforsale.info/database/what-s-the-impact/contract-failures-2.html>.

⁸⁹ Centre for Health and the Public Interest, *The Contracting NHS – Can the NHS Handle the Outsourcing of Clinical Services?* (March 2015)

⁹⁰ *Ibid.*, 4.

Some of these factors are apparent in an example cited by the CHPI – Castlebeck Care’s running of the Winterbourne View hospital, a private hospital for mentally disabled adult patients referred by the NHS. Abuse of patients was uncovered, and it was found that little monitoring of the contract had occurred and that the NHS had, despite the failure of Castlebeck to discharge its contractual obligations, continued to place patients at the hospital. While clearly an instance of regulatory failure on the part of the NHS, the underlying reason for Castlebeck’s non-performance of obligations under the contract could be traced to the need to discharge another kind of obligation discussed earlier in this article – namely, the obligation to pay interest on debt. A private equity firm had purchased Castlebeck and the debt that the company was carrying attracted an annual interest payment of £38m. As the surplus from running the hospital was used to pay this, the company’s management needed to find ways to cut back on costs within the hospital, resulting in the failures – including inadequate staff levels and lack of staff training – that ultimately led to the abuse of patients.

The foregoing examples demonstrate that obligations do not fall on all contracting parties in the healthcare sphere. The cause of this position, however, is not always identical. Thus, whereas in some cases, such as the PFI, companies providing finance do not bear the risk of adverse economic outcomes owing to the lack of assignation of obligation within the contract, in others it is the failure, through unwillingness or otherwise, to enforce stipulated contractual obligations that renders one of the contracting parties – the private provider – effectively free from those obligations. But what structures or determines this state of affairs? Two points can be made in

answer to this question – both of which, it is argued, need to be kept in mind when attempting to understand the dynamics at play here. First, and as the Castlebeck example perhaps most clearly illustrates, one source of the effective absence of duty can be obligations of a different sort emanating from elsewhere – in that case, from the financial model upon which private equity operates (one demand being the obligation to maintain debt interest payments). This points to the presence of a hierarchy of obligation, in which obligations to finance take precedence over those of adequate care. In terms of bonding, it denotes a situation in which the strengthening and maintenance of one type of bond (the tie to finance capital) necessitates the loosening of other forms (for instance, that between professional carer and patient, where failure to discharge professional duties of care to patients may attract no sanction). But it also signals an incipient transformation in the foundational obligations at the heart of the NHS. Thus, whereas these have traditionally concerned the obligation to provide access to healthcare based on need and not ability to pay characteristic of a publicly funded universal healthcare system, the examples described above suggest that this obligation, while still present, is slowly ceding ground to the types of obligation owed to finance capital and the emerging importance of (a new sense of) the ability to pay – not for medical treatment this time, but in order to maintain payments of debt and interest. And it is contract through which this shifting dynamic is mediated. As such, and in line with Supiot's characterisation of its contemporary function, contract can be considered as being bound up here with the legitimisation of power – in this case, the power of finance. In Streeck's terminology, it signals the rising importance within the NHS of the *Marktvolk* (the 'people of the market') and the declining importance of the

Staatsvolk ('the general citizenry') – at least insofar as citizens have any say over the marketisation of the NHS; that they continue to pay their taxes is, as has been noted, very important insofar as the ability of the state to maintain debt and interest repayments is concerned. As the foregoing examples testify, whether private consortia supplying finance as part of PFI schemes or private healthcare providers, it is the confidence of market players that the state is increasingly careful to sustain,⁹¹ something that results in the prioritising of obligations to finance over those associated with the healthcare of patients. Unlike the *Staatsvolk*, whose ties to the state are of an ongoing, public character and express 'a duty of loyalty' 'in return for the state's role in safeguarding their livelihood' (although, as the discussion regarding the legitimacy of taxation above suggests, this may be questioned today), the people of the market are bound to the state 'purely by [ephemeral] contractual ties', which give rise to rights against the state deriving from private, rather than from public, law.

The second point relating to the question regarding what structures or determines the lack, or unequal, assignation of obligation within the contracts under discussion concerns the role of the state. It is tempting to think that, like citizens, states are subject to economic forces and laws that they are incapable of shaping or changing. The foregoing discussion would certainly seem to point in this direction. Decisions not to impose contractual obligations on private providers or follow up on the breach of those that do exist could be interpreted as symptomatic of the need

⁹¹ See S Gill, 'The Constitution of Global Capital' (2000; PDF document available at: <http://stephengill.com/news/wp-content/uploads/Gill-2000-Constitution-of-Global-Capitalism.pdf>)

simply to obey such forces; in other words, owing to forces beyond one's control, there was really no choice but to let those private providers off the hook. But from where do those economic forces and laws, and the obligations (such as those associated with debt) accompanying them, emanate? The danger here lies in forgetting that the state is integral in constructing and maintaining the economy and that it is the source of the laws that are foundational in establishing markets. Despite appearing as such, the type of economic settlement and accompanying state and citizen obligations in any era are not inevitable, but the outcomes of deliberate policies. Thus, the debt and interest repayments associated with the PFI and the skewed obligations of contracts between the state and private health care providers, are symptoms of political choices made decades ago, rather than what appear to be the inevitable results of market forces. They are the consequences of decisions to lower taxation rates, reducing the money available for public services, which is filled by increased borrowing and the involvement of the private sector in the delivery of healthcare; of choices to have recourse to finance capital as the source of debt – as Streeck says of the debt state: '[I]t *subjects itself* and its activity to the control of creditors in the shape of 'markets''.⁹²; and decisions to create what is effectively a market for the provision of publicly funded healthcare by instituting a tendering process for the delivery of NHS healthcare and using competition law to ensure this is strictly enforced.⁹³ On the other hand, to the extent that the developments and obligations traced in this section might be deemed to be the result of so-called globalising forces over which states have no control, we would do well to recall Pierre Bourdieu's analysis of the integral role of the state in this phenomenon:

⁹² Streeck, *op cit.*, 78. Emphasis added.

⁹³ See the Health and Social Care Act 2012.

Paradoxically, it is *states* that have initiated the economic measures (of deregulation) that have led to their economic disempowerment. And contrary to the claims of both the advocates and the critics of the policy of ‘globalization’, states continue to play a central role by endorsing the very policies that tend to consign them to the sidelines.⁹⁴

V. CONCLUSION

That the particular form of an economy and the types of obligation accompanying it are the results of political choices can be demonstrated by reference to the historical changes this article has sought to chart. Against stern opposition from the medical profession, Bevan developed and implemented a new form and way of thinking about the delivery of healthcare in Britain, which, *inter alia*, had implications for the prevailing understanding of obligation in this context. As the examples cited in this article attest, Bevan’s NHS, in turn, has been subject to changes – driven by political choices, which were (and continue to be) themselves contested – that have affected the nature and sense of the obligations owed within the context of this institution. This suggests not only the central role of deliberate policy making but also of political struggle and contestation. This is important to remember, especially at a time when the privatisation and marketisation of the NHS are steadily gaining ground. Thus, while such phenomena and the obligations accompanying them may appear as inevitable and unstoppable forces, given history reveals alternative bases upon which the NHS was built, this is not necessarily the case. Returning to Bourdieu, he notes that things that are taken for granted and incontestable today – what he

⁹⁴ P Bourdieu, *Firing Back: Against the Tyranny of the Market 2* (London: Verso, 2003) 14. Emphasis in original.

calls *doxa* ('the contrary is unthinkable...this is how things are'⁹⁵) – were, when considered historically, 'often the product of a struggle'. As he says, while writing of the state: 'There is nothing that is constitutive of the state as it is taken for granted today that was not obtained without drama; everything was conquered. The strength of historical evolution, however, is to dismiss the defeated lateral possibilities, not to the realm of the forgotten, but to the unconscious'.⁹⁶ Arguably, Bevan's vision for the NHS, with its principles of decommodification, solidarity, and public service, became, not without a struggle, a *doxa* – something taken for granted and not open to question. Over the last 40 years or so, the sorts of principles characteristic of healthcare delivery prior to the NHS – marketisation, the centrality of the cash nexus, and healthcare as a mainly private good – have reappeared within the NHS itself. One view of this would be that the depth of penetration of those principles has resulted in a new *doxa* – one in which marketisation, privatisation, and individualisation are now taken for granted and rendered unquestionable. However, despite the developments discussed in this article, the NHS has not entirely succumbed to the march of neoliberal policies. It continues to assert the principle of access to healthcare free at the point of need and to implement this in practice, insofar as it is possible to do so; and its professionals continue to characterise themselves as public servants devoted to their patients. This suggests that the current era of the NHS is one in which the struggle over its future direction and nature continues to be a live and pressing issue. By excavating some of the heritage of this institution, in particular the notion of obligation synonymous with its

⁹⁵ P Bourdieu, *On the State: Lectures at the Collège de France, 1989-1992* (Cambridge: Polity, 2014) 256.

⁹⁶ *Ibid.*, 174.

founding, one of the purposes of this article has been to recall and highlight the types of collective bond envisaged at its origins. This is not only to enable an analysis of how those bonds differ from those that have emerged in recent decades – including the self-binding of individual obligation and the increasingly important ties to finance – but to hold them up against those new notions, and, in so doing, stress the importance of protecting them from becoming, in Bourdieu's words, 'defeated lateral possibilities' dismissed to the realm of the unconscious.